

SERFF Tracking Number: AMNA-125968137 State: Arkansas
Filing Company: American National Insurance Company State Tracking Number: 41678
Company Tracking Number: FORM 10193
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form 10193
Project Name/Number: /

Filing at a Glance

Company: American National Insurance Company

Product Name: Form 10193

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMNA-125968137 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 41678

Co Tr Num: FORM 10193

Authors: Tracey Johnfroe,
Gwendolyn Evans

Date Submitted: 02/27/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 03/02/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/02/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/02/2009

Created By: Tracey Johnfroe

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Tracey Johnfroe

Filing Description:

Arkansas Insurance Department

Compliance - Life and Health

1200 West Third Street

Little Rock AR 72201-1904

American National Insurance Company (NAIC: 60739 FEIN: 74-0484030)

Filing of:

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Form 10193-AR

Form 10100

Form 10065

Form 9264

Form 8313

Form 8313-A

Form 8313-B

Form 8313-C

Form 8313-D

Form 4643

Form 4644

Form 4687

Form 4688

Form 4689

Form 4690

Form 3517-AR

Form 10228

SERFF Tracking Number AMNA-125968137

Company Tracking Number: 10193

Dear Sir or Madam,

Please find the above referenced forms attached for your department's review and approval. These are new forms and are not intended to replace any previously approved forms.

Form 10193-AR is an Application for Life Insurance. It will be used on all lines of fully underwritten life insurance products offered by American National Insurance Company including, but not limited to:

- Participating Whole Life (Participating and Non-Participating);
- Traditional Universal Life;
- Indexed Universal Life;
- Variable Universal Life; and
- Term Life

This application will be attached to and made a part of the policy contract.

Within the application, there are medical history and other similar type questions used to assist Us in determining the

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insurability and risk class of the applicant. For some of these questions, a 'yes' answer will prompt the use of a supplemental questionnaire in order to gather more information. In addition to a 'yes' answer, the underwriter can request the completion of a supplement questionnaire at their discretion, usually based on findings in a report or medical examination on the applicant obtained during the underwriting process. When used, these questionnaires will be attached to and considered a part of the application, which is attached to and made a part of the policy.

These questionnaires are as follows:

- Form 10100 – Blood Pressure Questionnaire
- Form 10065 – Proposed Insured's Chest Pain Questionnaire
- Form 9264 – Foreign Travel Questionnaire
- Form 8313 – Aviation Questionnaire
- Form 8313-A – Skin and Scuba Diving Questionnaire
- Form 8313-B – Motor Sports Questionnaire
- Form 8313-C – Sport, Amusement or Avocation Questionnaire
- Form 8313-D – Racing Questionnaire
- Form 4691 – Check-Up Questionnaire
- Form 4690 – Diabetic Questionnaire
- Form 4689 – Disabled Applicant Questionnaire
- Form 4688 – Epilepsy/Seizure Questionnaire
- Form 4687 – Respiratory Questionnaire
- Form 4644 – Alcohol Use Questionnaire
- Form 4643 – Drug Use Questionnaire

Form 3517-AR is the Declaration of Insurability form. This form is used in conjunction with the application when a Premium Payor Benefit/Rider is applied for. The person named as the Premium Payor must complete the form and submit the completed form to Us with the application for life insurance. When used, this form will be attached to and considered an extension of the application, and will become a part of the policy.

Form 10228 is the Application - Additional Beneficiary Page for Life Insurance form. This form is used to designate beneficiaries for the policy being applied for. At times, multiple beneficiaries can be named, or space is an issue on the application when a long name or title needs to be written. Also, the applicant may have special instructions regarding the designation of a beneficiary(ies). In lieu of being restricted by the space provided on the application, this form may be completed and submitted with the application. When used, this form will be attached to and considered an extension of the application, and will become a part of the policy.

Additional components / information associated with this filing are as follows and have been enclosed (when applicable) for your review:

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- Statement of Variability
- Certification/Notice
- Payment for the required filing fee has been transmitted via EFT through SERFF in the amount of \$ 550.00

Should any additional information be required, or if there are any questions, please contact me at phone number (409) 763-4661 X 5438 or e-mail address tracey.johnfroe@anico.com.

Company and Contact

Filing Contact Information

Tracey Johnfroe, Life Policy Analyst Tracey.Johnfroe@ANICO.com
 One Moody Plaza 409-463-4661 [Phone] 5438 [Ext]
 Actuarial Product Development 709-766-6933 [FAX]
 14th Floor
 Galveston, TX 77550

Filing Company Information

American National Insurance Company CoCode: 60739 State of Domicile: Texas
 One Moody Plaza Group Code: 408 Company Type:
 Galveston, TX 77550 Group Name: State ID Number:
 (409) 763-4661 ext. [Phone] FEIN Number: 74-0484030

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Insurance Company	\$100.00	02/27/2009	26020152

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/02/2009	03/02/2009

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Disposition

Disposition Date: 03/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Cover Letter		Yes
Form	APPLICATION FOR LIFE INSURANCE		Yes
Form	DECLARATION OF INSURABILITY		Yes
Form	DRUG USE QUESTIONNAIRE		Yes
Form	ALCOHOL USE QUESTIONNAIRE		Yes
Form	RESPIRATORY QUESTIONNAIRE		Yes
Form	EPILEPSY/SEIZURE QUESTIONNAIRE		Yes
Form	DISABLED APPLICANT QUESTIONNAIRE		Yes
Form	DIABETIC QUESTIONNAIRE		Yes
Form	CHECK-UP QUESTIONNAIRE		Yes
Form	AVIATION QUESTIONNAIRE		Yes
Form	SKIN AND SCUBA DIVING QUESTIONNAIRE		Yes
Form	MOTOR SPORTS QUESTIONNAIRE		Yes
Form	SPORT, AMUSEMENT OR AVOCATION QUESTIONNAIRE		Yes
Form	RACING QUESTIONNAIRE		Yes
Form	FOREIGN TRAVEL QUESTIONNAIRE		Yes
Form	PROPOSED INSURED'S CHEST PAIN QUESTIONNAIRE		Yes
Form	BLOOD PRESSURE QUESTIONNAIRE		Yes
Form	APPLICATION-ADDITIONAL BENEFICIARY PAGE FOR LIFE INSURANCE		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	10193-AR	Application/	APPLICATION FOR Enrollment LIFE INSURANCE Form	Initial		50.000	10193-AR.pdf
	3517-AR	Data/Declar	DECLARATION OF ation PagesINSURABILITY	Initial			3517-AR.pdf
	4643	Other	DRUG USE QUESTIONNAIRE	Initial			4643.pdf
	4644	Other	ALCOHOL USE QUESTIONNAIRE	Initial			4644.pdf
	4687	Other	RESPIRATORY QUESTIONNAIRE	Initial			4687.pdf
	4688	Other	EPILEPSY/SEIZURE QUESTIONNAIRE	Initial			4688.pdf
	4689	Other	DISABLED APPLICANT QUESTIONNAIRE	Initial			4689.pdf
	4690	Other	DIABETIC QUESTIONNAIRE	Initial			4690.pdf
	4691	Other	CHECK-UP QUESTIONNAIRE	Initial			4691.pdf
	8313	Other	AVIATION QUESTIONNAIRE	Initial			8313.pdf
	8313-A	Other	SKIN AND SCUBA DIVING QUESTIONNAIRE	Initial			8313-A.pdf
	8313-B	Other	MOTOR SPORTS QUESTIONNAIRE	Initial			8313-B.pdf
	8313-C	Other	SPORT, AMUSEMENT OR AVOCATION QUESTIONNAIRE	Initial			8313-C.pdf

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8313-D	Other	RACING QUESTIONNAIRE	Initial	8313-D.pdf
9264	Other	FOREIGN TRAVEL QUESTIONNAIRE	Initial	9264.pdf
10065	Other	PROPOSED INSURED'S CHEST PAIN QUESTIONNAIRE	Initial	10065.pdf
10100	Other	BLOOD PRESSURE QUESTIONNAIRE	Initial	10100.pdf
10228	Application/ Enrollment Form	APPLICATION- ADDITIONAL BENEFICIARY PAGE FOR LIFE INSURANCE	Initial	10228.pdf



Application for Life Insurance

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999



1. PRIMARY PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ b. Birthplace: City _____ State _____ Country _____

c. Date of birth: Month/Day/Year _____ d. Age last birthday _____ e. Height _____ f. Weight _____ g. Social Security/Tax ID number _____

h. Gender Male Female i. Marital status: Married Separated Single Widowed Divorced

j. Have you ever used tobacco or nicotine in any form? Yes No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | _____

k. Residence address: Number/Street _____ City _____ State _____ ZIP _____

l. Years at this residence _____ m. Personal telephone _____ n. Annual Income _____ Net worth _____
| (_____) _____ | \$ _____ | \$ _____

o. Type of business _____ Employer name _____ p. Business telephone _____
| _____ | (_____) _____

q. Occupation/Job title _____ Job duties (Be specific.) _____ r. Date of employment: Month/Year _____

s. Business address: Number/Street _____ City _____ State _____ ZIP _____

t. U.S. Citizen: Yes No If No, type of Visa _____ Expiration Date _____

2. ADDITIONAL PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ b. Birthplace: City _____ State _____ Country _____

c. Date of birth: Month/Day/Year _____ d. Age last birthday _____ e. Height _____ f. Weight _____ g. Social Security/Tax ID number _____

h. Gender Male Female i. Marital status: Married Separated Single Widowed Divorced

j. Have you ever used tobacco or nicotine in any form? Yes No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | _____

k. Residence address: Number/Street _____ City _____ State _____ ZIP _____

l. Years at this residence _____ m. Personal telephone _____ n. Annual Income _____ Net worth _____
| (_____) _____ | \$ _____ | \$ _____

o. Type of business _____ Employer name _____ p. Business telephone _____ q. Relationship to primary proposed insured _____

r. Occupation/Job title _____ Job duties (Be specific.) _____ s. Date of employment: Month/Year _____

t. Business address: Number/Street _____ City _____ State _____ ZIP _____

u. U.S. Citizen: Yes No If No, type of Visa _____ Expiration Date _____

3. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name _____ First name _____ M.I. _____ b. Relationship to primary proposed insured _____

c. Gender Male Female d. Date of birth: Month/Day/Year _____ e. Age last birthday _____ f. Social Security/Tax ID number _____ g. If Trust, date created _____

h. Mailing address: Number/Street _____ City _____ State _____ ZIP _____

i. Contingent owner (If any): Last name _____ First name _____ M.I. _____ j. Relationship to primary proposed insured _____



4. SECONDARY OR ALTERNATE ADDRESSEE (if applicable)

Name | _____ Address: Number/Street | _____
City | _____ State | _____ ZIP | _____

5. CHILDREN PROPOSED FOR INSURANCE (COMPLETE FOR CHILDREN TERM RIDER)

Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Age	Ht./Wt.	Gender: M/F	Soc. Sec./Tax ID#
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

- a. Has the name of any child age 18 or younger been omitted? Yes (Explain.) | _____ No
- b. Is any child NOT living at the same address as the proposed insured? Yes (Explain.) | _____ No

6. BENEFICIARY FOR PRIMARY PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Contingent: Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Gender	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

7. BENEFICIARY FOR ADDITIONAL PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally.)

Primary: Last name	First name	M.I.	Relationship to additional proposed insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

8. PRODUCT INFORMATION

a. Plan of insurance (Specify number of years if Term) _____ b. Amount of insurance _____

c. Premium amount \$ _____ Mode: Annual Semiannual Quarterly Monthly Single premium

d. If all proposed insured(s) are acceptable risks on a nonrated basis, but the premium quoted will not purchase the face amount requested:

- Do NOT change premium. Change face amount.
- Do NOT change face amount. Change premium.

Was automatic premium loan elected? Yes No (In Rhode Island, automatic premium loan is required, unless otherwise elected.)

If Participating Whole Life

e. Dividend option: Cash Premium reduction Paid-up additions Accumulate at interest

If Universal Life (including Indexed Universal Life and Variable Universal Life)

f. Death benefits options (Elect one - If no option is selected, Option "A" will be issued) Option A Option B Option C

If Indexed Universal Life

g. Initial Allocation of Net Premiums (Allocation must be designated in percentages and must total 100%)

_____ % Fixed Interest Crediting Option _____ % Indexed Interest Crediting Option

If Variable Universal Life

h. Guaranteed Coverage Period: (Elect one.) 10-year 25-year Other _____

Amount paid with application: \$ _____ (Check must be payable to American National Insurance Company.)



9. RIDERS/BENEFITS (Complete insurability application, if necessary.)

a. Optional benefits/riders:

- Optional benefits/riders including Premium waiver, Waiver of stipulated premium, Accidental death, Children term, Spouse term, Guaranteed increase option, Additional insurance option, Return of Premium Rider, Paid Up Additions Rider, Premium for PUA, Premium payor, Coverage continuation rider, Other insured rider, Level term.

Other: Type of Rider, Name of insured, Amount of insurance

Beneficiary for Other Insured Rider Coverage (Unless specified, all beneficiaries in the same class share equally.)

Table with columns: Primary: Last name, First name, M.I., Relationship to other insured rider, Date of Birth: Mo./Day/Yr., Gender: M/F, Soc. Sec./Tax ID#, Date of trust: Mo./Day/Yr., % payable

Special beneficiary settlement options: Yes No (If "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)

10. INSURANCE AND REPLACEMENTS

- Do you have existing life insurance or annuity coverage? Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company? Total Insurance/Annuities in force on Proposed Insured(s):

Table with columns: Full Name of Company, Policy No., Issue Date, Insured's Name, Plan, Amount, See "10b"

Accidental Death \$ Company

11. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents: Is parent living (Y/N), Age if living, Age at death, Cause of death. Father, Mother

Siblings: Number of living, Number deceased, Age at death, Cause of death

- Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?

12. ADDITIONAL PROPOSED INSURED FAMILY HISTORY - COMPLETE IF AMOUNT OF INSURANCE IS \$100,000 OR GREATER

Parents: Is parent living (Y/N), Age if living, Age at death, Cause of death. Father, Mother

Siblings: Number of living, Number deceased, Age at death, Cause of death

- Did (Does) anyone in the immediate family have a history of heart disease or stroke/cerebral vascular accident? Did (Does) anyone in the immediate family have a history of internal cancer or melanoma?



13. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC

a. Family physician, specialist or clinic of **proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
_____	_____	_____	_____
Address: Number/Street	City	State ZIP	Provider telephone number
_____	_____	_____ _____	(____) _____

b. Family physician, specialist or clinic of **additional proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
_____	_____	_____	_____
Address: Number/Street	City	State ZIP	Provider telephone number
_____	_____	_____ _____	(____) _____

14. MEDICAL HISTORY QUESTIONS—LIFETIME

(For questions "14.a." through "16.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 17.)

a. Is any proposed insured taking any medication(s)? Yes No (If "Yes," list medications and prescribed dosages).

HAS ANY PROPOSED INSURED EVER ...

- b. had a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels?..... Yes No
- c. had cancer, a tumor or abnormal growth of any kind? Yes No
- d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? Yes No

15. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS ...

- a. had seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system? ... Yes No
- b. had asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system?..... Yes No
- c. had any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis? Yes No
- d. had any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? Yes No
- e. had diabetes or any disease of the thyroid or other gland? Yes No
- f. had arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin? Yes No
- g. had treatment or counseling for use of alcohol or alcoholism? Yes No
- h. had treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? Yes No
- i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed? Yes No
- j. If any proposed insured(s) is less than one year old, give birth weight: | _____ lb. | _____ oz. Was birth premature? Yes No

16. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS ...

- a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? Yes No
- b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test? Yes No
- c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed? Yes No



17. MEDICAL HISTORY EXPLANATIONS

(Give full details below of all "Yes" answers to questions "14.a." through "16.c.")

Question Person Reason, condition, disease, injury, etc. Date
% of recovery Name of attending physician Attending physician address: Number/Street City State

18. INSURANCE HISTORY AND NON-MEDICAL HAZARDS

- a. Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate?
b. Has any proposed insured in the last six (6) months, applied for — or is any proposed insured contemplating applying for — other insurance with this, or any other, company?
c. Has any proposed insured, in the past five (5) years, made — or is any proposed insured contemplating making — flights as a pilot, student pilot, crew member, or observer?
d. Has any proposed insured, in the past five (5) years, engaged in — or does any proposed insured intend to engage in — any hazardous avocation or sport, such as SCUBA diving, parachuting, hang-gliding, vehicle racing, or other hazardous avocation(s)?
e. Has any proposed insured, in the past five (5) years, been convicted of a felony?
f. Is any proposed insured currently on parole or probation?
g. Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?
h. Does any proposed insured plan to travel outside of the United States for more than four (4) weeks?

Primary Proposed Insured

i. Driver's license number: State:
j. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?
k. Do you have any other moving violations in the last five (5) years?

Additional Proposed Insured

l. Driver's license number: State:
m. Have you had a charge or conviction of DWI/DUI or reckless driving in the last five (5) years?
n. Do you have any other moving violations in the last five (5) years?



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declares for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true. They also agree that: (1) these answers as written: (i) were given to induce the company to issue a policy; and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial number as this application, no policy will be effective until it is: (i) issued; (ii) delivered to the applicant; and (iii) the full first premium paid, all during the lifetime and good health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be effective unless agreed to by the applicant in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and (5) only the president or a vice president or secretary of the company has the authority to waive any of the company rights or requirements or to waive or alter any of the provisions of: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FCRA / MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

For Indexed Universal Life:

I understand that I am applying for an indexed universal life policy and that while the value of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investment.

For Variable Universal Life:

I understand that I am applying for a Variable Universal Life Policy. The accumulation value may increase or decrease depending on investment returns and the death benefit may be variable or fixed depending on the death benefit option selected.

Date: Month/Day/Year Signed at: City State Country

_____ | _____ | _____ | _____

Witnessed by: Signature of licensed agent Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

X _____ **X** _____

Print agent's name Signature of additional person(s) proposed for insurance

_____ **X** _____

Agent's state license number Signature of additional person(s) proposed for insurance

_____ **X** _____

Agent's company personal code Signature of owner if other than proposed insured

_____ **X** _____



19. SOLICITING AGENT'S REPORT: THESE QUESTIONS MUST BE ANSWERED IN EVERY CASE

- a. How long have you personally known the proposed insured? Years | _____ Months | _____
b. By whom will premiums be paid? [] Owner [] Applicant [] Other (If "Other," explain.) | _____
c. What is your estimate of the premium payor's annual income? \$ _____ and worth? \$ _____
d. If the proposed insured is a child, how much insurance does the Parent/Premium Payor have in force on his/her own life? \$ _____
e. Give any other surname(s) used by any proposed insured in the last five years. | _____
f. If beneficiary is not a relative, explain insurable interest. | _____
g. Did you see each person proposed for insurance when the application was completed? [] Yes [] No
h. Was beneficiary present during the completion of the application? [] Yes [] No
i. As agent, do you certify that, on the date of this application, you asked the proposed insured each question in the application, recorded the answers given you, witnessed such person's signature, and collected the initial premium shown in the application? [] Yes [] No
j. Do you have knowledge of any health history of any proposed insured not listed on this application? [] Yes [] No
k. As agent, did you determine this applicant's insurable objective and/or financial need? [] Yes [] No
l. As agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? [] Yes [] No
m. As agent, have you complied with state replacement regulations? [] Yes [] No
n. As agent, did you include individualized sales proposals in your presentations? [] Yes [] No
(If the primary proposed insured is replacing an existing plan(s) with this policy, the comparative information forms for each policy to be replaced, and copies of all sales material, MUST be included with this application sent to the home office.)
o. If a child, are there any other minor age siblings in the home? [] Yes [] No
If yes, do they have the same amount of coverage in force or applied for? [] Yes [] No If "no", explain _____

Dated at: City _____ Month/Day/Year _____
Corporation name _____ Tax ID _____ Social Security number _____
Branch office number and PSO code _____ Agent personal code or number _____ CSSD District Code 2 _____ Agency # _____
Licensed agent's signature _____ Agent e-mail _____ Telephone number _____
X _____ | _____ | (_____) _____

20. SPECIAL ISSUE INSTRUCTIONS TO HOME OFFICE

If prior quote was reviewed, please provide quote number: | _____
Additional policy plan and amount
_____ \$ _____
Alternate policy plan and amount
_____ \$ _____
Are commissions to be split? [] Yes [] No (If "Yes," and split 50/50, list both agents' names and personal code number. If NOT, complete and submit Form 6151.)
Agent name _____ Personal code or number _____ Agent name _____ Personal code or number _____
Special Instructions: | _____

21. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:
Oral fluid test collected by agent [] Yes [] No Date collected? | _____ [] Lab ticket attached or affix barcode here: _____
Inspection ordered [] Yes [] No (If "Yes," give name of inspection service used.)

[] Exam by physician, full blood, HOS [] EKG [] X-ray [] Paramed, full blood, HOS [] Full blood, physical measurements, HOS
[] Paramed, HOS | _____ [] Other | _____
Name of approved paramed company? | _____
Were medical records (APS) ordered by producer? [] Yes [] No (If "Yes," give physician/clinic name)

Did you pay for the attending physician's statement? [] Yes [] No
(If "Yes," enter check # | _____ and amount \$ _____)
Has the application been reviewed for omissions and errors? [] Yes [] No
If "yes", by (name) _____



CONDITIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

**AMERICAN NATIONAL INSURANCE COMPANY
One Moody Plaza, Galveston, Texas 77550-7999**

**PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL INSURANCE COMPANY.
DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

I have received \$ _____ in connection with an application for life insurance bearing the same serial number as this receipt. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

- (1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
- (2) All medical examinations and tests required under the company's initial application requirements must be completed and the reports of those medical examinations and tests must be received at the company's home office within 45 days after the date of this receipt;
- (3) On the effective date, as defined below, all persons proposed for insurance must be in good health and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
- (4) There is no material misrepresentation in the application.

MAXIMUM AMOUNT LIMITATION: At no time and in no event shall the total liability of the company under this receipt and all other receipts providing conditional insurance coverage with the company on the lives of all the persons proposed for insurance exceed \$500,000.

EFFECTIVE DATE MEANS THE LATEST OF: (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

REFUND OF PAYMENT: If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the company's liability is limited to a refund of the amount paid. Only the president, a vice president or secretary of the company has the authority to waive any of the company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

Date: Month/Day/Year Signed at: City State Country

_____ | _____ | _____ | _____

Signature of licensed agent

X _____

I have read this conditional receipt. It has been explained to me by the agent.

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

X _____

Signature of Owner

X _____



AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED.

AMERICAN NATIONAL INSURANCE COMPANY
One Moody Plaza, Galveston, Texas 77550-7999

Thank you for considering American National Insurance Company as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

Medical Information Bureau (MIB) Pre-notification — Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the bureau's file, you may contact the bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the bureau's information office is: Medical Information Bureau, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, website address www.mib.com, telephone number (617) 426-3660. The American National Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Fair Credit Reporting Act Pre-notification — Federal and state laws require notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or, for the appropriate fee, receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.



Declaration of Insurability

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999



1. PRIMARY PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ b. Birthplace: City _____ State _____ Country _____

c. Date of birth: Month/Day/Year _____ d. Age last birthday _____ e. Height _____ f. Weight _____ g. Social Security/Tax ID number _____

h. Gender Male Female i. Marital status: Married Separated Single Widowed Divorced

j. Have you ever used tobacco or nicotine in any form? Yes No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | _____

k. Residence address: Number/Street _____ City _____ State _____ ZIP _____

l. Years at this residence _____ m. Personal telephone _____ n. Annual Income _____ Net worth _____
| (_____) _____ | \$ _____ | \$ _____

o. Type of business _____ Employer name _____ p. Business telephone _____
| _____ | (_____) _____

q. Occupation/Job title _____ Job duties (Be specific.) _____ r. Date of employment: Month/Year _____

s. Business address: Number/Street _____ City _____ State _____ ZIP _____

t. U.S. Citizen: Yes No If No, type of Visa _____ Expiration Date _____

2. ADDITIONAL PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ b. Birthplace: City _____ State _____ Country _____

c. Date of birth: Month/Day/Year _____ d. Age last birthday _____ e. Height _____ f. Weight _____ g. Social Security/Tax ID number _____

h. Gender Male Female i. Marital status: Married Separated Single Widowed Divorced

j. Have you ever used tobacco or nicotine in any form? Yes No
(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used?) Month/Year | _____

k. Residence address: Number/Street _____ City _____ State _____ ZIP _____

l. Years at this residence _____ m. Personal telephone _____ n. Annual Income _____ Net worth _____
| (_____) _____ | \$ _____ | \$ _____

o. Type of business _____ Employer name _____ p. Business telephone _____ q. Relationship to primary proposed insured _____

r. Occupation/Job title _____ Job duties (Be specific.) _____ s. Date of employment: Month/Year _____

t. Business address: Number/Street _____ City _____ State _____ ZIP _____

u. U.S. Citizen: Yes No If No, type of Visa _____ Expiration Date _____

3. CHILDREN PROPOSED FOR INSURANCE (COMPLETE FOR CHILDREN TERM RIDER)

Last name	First name	M.I.	Relationship to primary proposed insured	Date of Birth: Mo./Day/Yr.	Age	Ht./Wt.	Gender: M/F	Soc. Sec./Tax ID#
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

a. Has the name of any child age 18 or younger been omitted? Yes (Explain.) | _____ No

b. Is any child NOT living at the same address as the proposed insured? Yes (Explain.) | _____ No



4. FAMILY PHYSICIAN, SPECIALIST, OR CLINIC

a. Family physician, specialist or clinic of **proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
_____	_____	_____	_____
Address: Number/Street	City	State ZIP	Provider telephone number
_____	_____	_____ _____	(_____) _____

b. Family physician, specialist or clinic of **additional proposed insured**:

Provider name	Date last visited	Reason for visit	HMO patient ID number
_____	_____	_____	_____
Address: Number/Street	City	State ZIP	Provider telephone number
_____	_____	_____ _____	(_____) _____

5. MEDICAL HISTORY QUESTIONS—LIFETIME

(For questions "5.a." through "7.c.", underline the reason for any "Yes" answer(s) and give complete details as requested in Section 8.)

a. Is any proposed insured taking any medication(s)? Yes No (If "Yes," list medications and prescribed dosages).

HAS ANY PROPOSED INSURED EVER ...

- b. had a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels?..... Yes No
- c. had cancer, a tumor or abnormal growth of any kind? Yes No
- d. been told he/she had an Immune Deficiency Disorder, AIDS, AIDS related complex (ARC), or test results indicating exposure to the AIDS virus? Yes No

6. MEDICAL HISTORY QUESTIONS— LAST TEN YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS ...

- a. had seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system? ... Yes No
- b. had asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD) or any disease or abnormality of the respiratory system?..... Yes No
- c. had any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis?..... Yes No
- d. had any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? Yes No
- e. had diabetes or any disease of the thyroid or other gland? Yes No
- f. had arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin?..... Yes No
- g. had treatment or counseling for use of alcohol or alcoholism? Yes No
- h. had treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? Yes No
- i. Does any proposed insured currently have any medical concerns for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed?..... Yes No
- j. If any proposed insured(s) is less than one year old, give birth weight: | _____ lb. | _____ oz. Was birth premature? Yes No

7. MEDICAL HISTORY QUESTIONS— LAST FIVE YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS ...

- a. consulted or been treated or examined by any physician or practitioner for any cause not previously mentioned in this application? Yes No
- b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test? Yes No
- c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed? Yes No

8. MEDICAL HISTORY EXPLANATIONS

(Give full details below of all "Yes" answers to questions "5.a." through "7.c.")

Question	Person	Reason, condition, disease, injury, etc.	Date
_____	_____	_____	_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City State
_____	_____	_____	_____ _____
Question	Person	Reason, condition, disease, injury, etc.	Date
_____	_____	_____	_____
% of recovery	Name of attending physician	Attending physician address: Number/Street	City State
_____	_____	_____	_____ _____



AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations;
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declares for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true. They also agree that: (1) these answers as written: (i) were given to induce the company to issue a policy; and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial number as this application, no policy will be effective until it is: (i) issued; (ii) delivered to the applicant; and (iii) the full first premium paid, all during the lifetime and good health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be effective unless agreed to by the applicant in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and (5) only the president or a vice president or secretary of the company has the authority to waive any of the company rights or requirements or to waive or alter any of the provisions of: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FCRA / MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

Date: Month/Day/Year Signed at: City State Country
 _____ | _____ | _____ | _____

Witnessed by: Signature of licensed agent Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)
 X _____ X _____

Print agent's name Signature of additional person(s) proposed for insurance
 _____ X _____

Agent's state license number Signature of additional person(s) proposed for insurance
 _____ X _____

Agent's company personal code Signature of owner if other than proposed insured
 _____ X _____



9. REQUIREMENTS ORDERED: SEE CURRENT UNDERWRITING GUIDELINES FOR REQUIREMENTS

Indicate which of the following was (were) ordered by producer:

Oral fluid test collected by agent..... Yes No

Date collected? | _____ Lab ticket attached or affix barcode here: _____

Inspection ordered Yes No (If "Yes," give name of inspection service used.)

Exam by physician, full blood, HOS

EKG

X-ray

Paramed, full blood, HOS

Full blood, physical measurements, HOS

Paramed, HOS | _____

Other | _____

Name of approved paramed company? | _____

Were medical records (APS) ordered by producer?..... Yes No

(If "Yes," give physician/clinic name) | _____

Did you pay for the attending physician's statement? Yes No

(If "Yes," enter check # | _____ and amount \$ _____)

Has the application been reviewed for omissions and errors? Yes No

If "yes", by (name) | _____



CONDITIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

AMERICAN NATIONAL INSURANCE COMPANY
One Moody Plaza, Galveston, Texas 77550-7999

**PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL INSURANCE COMPANY.
DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

I have received \$ _____ in connection with an application for life insurance bearing the same serial number as this receipt. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

- (1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
- (2) All medical examinations and tests required under the company's initial application requirements must be completed and the reports of those medical examinations and tests must be received at the company's home office within 45 days after the date of this receipt;
- (3) On the effective date, as defined below, all persons proposed for insurance must be in good health and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
- (4) There is no material misrepresentation in the application.

MAXIMUM AMOUNT LIMITATION: At no time and in no event shall the total liability of the company under this receipt and all other receipts providing conditional insurance coverage with the company on the lives of all the persons proposed for insurance exceed \$500,000.

EFFECTIVE DATE MEANS THE LATEST OF: (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

REFUND OF PAYMENT: If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the company's liability is limited to a refund of the amount paid. Only the president, a vice president or secretary of the company has the authority to waive any of the company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

Date: Month/Day/Year Signed at: City State Country

_____ | _____ | _____ | _____

Signature of licensed agent

X _____

I have read this conditional receipt. It has been explained to me by the agent.

Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

X _____

Signature of Owner

X _____

**AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED.**

AMERICAN NATIONAL INSURANCE COMPANY
One Moody Plaza, Galveston, Texas 77550-7999

Thank you for considering American National Insurance Company as your insurance carrier.

One of the prime objectives of our company is to provide insurance at the lowest possible cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure that each policyholder contributes his/her fair share of the cost. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports we may receive from doctors and hospitals who have attended you.

Medical Information Bureau (MIB) Pre-notification — Information regarding your insurability will be treated as confidential. The American National Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the bureau's file, you may contact the bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the bureau's information office is: Medical Information Bureau, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, website address www.mib.com, telephone number (617) 426-3660. The American National Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Fair Credit Reporting Act Pre-notification — Federal and state laws require notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or, for the appropriate fee, receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.



Drug Use Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Proposed Insured: _____ Birthdate: _____ File # _____

1. Do you use or have you used:

- | | Yes | No |
|--|--------------------------|--------------------------|
| A. Narcotics (codeine, heroin, morphine, opium, methadone, demerol, percodan, dilaudid, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Hallucinogens (LSD, mescaline, PCP, peyote, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Cannabis (marijuana, hashish, THC, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Stimulants (cocaine, crack, benzedrine, methamphetamine, amyl nitrite, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Sedatives (tuinal, seconal, nembital, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Tranquilizers (librium, valium, diazepam, halcion, quaalude, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. I.V. Drug use. | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Any other substance abuse? | <input type="checkbox"/> | <input type="checkbox"/> |

2. If YES for any of the above, please give details below:

Drug Used	Frequency (No. of times per week)	Dates Used From (mo/yr) To(mo/yr)	Name and Address of Prescribing Physician (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Drug use ever affect your job performance? Yes No If yes, give details _____

4. A. Have you ever sought, received or been advised to receive treatment because of your drug use? Yes No
If yes, indicate number of times treated _____, date(s) of treatment _____, name, address and phone number of any doctor, hospital, or treatment center involved. _____

B. Any medical complications as a result of this problem? Yes No If yes, explain _____

5. Have you ever been arrested or charged with any offense involving drugs, including driving under the influence of drugs or alcohol?
 Yes No If Yes, give details and driver's license number: _____

6. Do you or have you attended Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or any 12-step program or support group for alcohol or drugs? Yes No If yes, Date first attended: _____ Date last attended: _____

7. Please add any additional information which you feel is important concerning your use of drugs: _____

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature _____

Date _____

Witness _____

Date _____



Alcohol Use Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



NAME _____ DRIVER'S LICENSE # _____ STATE ISSUED _____

FILE # _____

1. Do you presently use or have you in the past used alcoholic beverages? Yes No

	PRESENT USE OF ALCOHOL			PAST USE OF ALCOHOL		
	Quantity Used	Frequency (Daily, Weekly, Monthly)	Dates Used From: To:	Quantity Used	Frequency (Daily, Weekly, Monthly)	Dates Used From: To:
Beer						
Wine						
Other Alcohol						

2. Have you changed your drinking habits? Yes No. If "Yes," Why? _____

3. Have you ever consulted, or been advised to consult, a hospital, physician or practitioner or received treatment for your alcohol use?

Yes No Date _____

Treatment Center/Doctor's Name _____

Address _____ City and State _____ ZIP _____ Phone # _____

4. Are you presently being treated for alcohol use? Yes No

5. Are you attending or have you ever attended any alcohol related, self-help organizations (e.g. Alcoholic Anonymous etc.)?

Yes No Date _____

Name of Organization _____ How often do you attend? _____

Date of First Attendance: _____ Do you still attend meetings? Yes No

6. Have you ever been convicted for driving while under the influence of alcohol?

Yes No Number of Times _____ Date(s) _____

7. Has alcohol use ever affected your job performance? Yes No If "Yes," furnish details _____

8. Do you have, or have you had, any medical complications as a result of this problem? Yes No. If "Yes," conditions such as:

Pancreatitis Gastritis Liver problems Other _____

9. In the past five years have you used any drug or narcotic (except prescribed by a physician) or received treatment or counseling for drug use?

(Drugs include, but are not limited to, barbiturates, heroin, cocaine, opiates, amphetamines, marijuana, hallucinogens.)

Yes No If "Yes," please explain _____

Furnish dates, name, address and phone number of Doctor(s) or Medical Facilities. _____

10. Please include any additional information which you feel is important.

I declare that the above information is true and complete and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Witness _____

Date _____



Respiratory Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name: _____ Birthdate: _____ File # _____

1. A. Do you have, or have you ever had: bronchitis asthma emphysema chronic cough wheezing
 chronic obstructive pulmonary disease pneumonia shortness of breath other (explain) _____

B. Cause Known? _____

2. How often do attacks occur and duration? _____

3. Date of last attack? _____

4. Are the attacks: Mild Moderate Severe

5. Indicate pattern of your attacks in the past five years:

- No change in symptoms. Improvement in symptoms. Increasing symptoms or more severe attacks.

6. Have you lost time from work? Yes No If yes, when, how long, why? _____

7. Have you been hospitalized in the last 5 years for a respiratory disorder? Yes No If yes,

Hospital	City, State & ZIP	Approximate date(s)

8. Provide the name(s) of the medications or type of treatment you take for your respiratory disorder.

Name, address and phone number of Primary Physician for respiratory condition. _____

9. Have pulmonary function studies and tests been performed? Yes No If yes, date and results _____

10. Do you use tobacco in any form? Yes No If yes, type and amount per day _____

If used in the past and quit, number of years, quantity and date of last use. _____

11. Do you have, or have you ever had any other medical disorder? If so, please describe, give dates and advise who treated.

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature

Date

Witness

Date



Epilepsy/Seizure Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

page 1 of 1

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name _____ Birthdate _____ File # _____

1. Date Diagnosed: _____

2. Type: _____

Petit Mal

Grand Mal

Other _____

3. Cause Known? _____

4. Number of attacks per year: _____

5. Approximate date of last attack: _____

6. Please indicate your medication(s), dosage, and amount each day: _____

7. If no longer on medication, when did you discontinue treatment and why? _____

8. A) Name, Address and Phone number of Doctor: _____

B) Date last seen for this condition: _____

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature

Date

Witness

Date



Disabled Applicant Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name _____ File # _____

1. What is your disability? _____

2. When was the onset of your disability? _____

3. What was the cause? _____

4. Does your disability affect your ability to either work or carry out normal daily activities? Yes No

If yes, give details _____

5. What was your job prior to your disability? _____

6. When do you expect to return to work? _____

7. Are you currently receiving Worker's Compensation, Unemployment or Disability payments? Yes No

8.

Name, Address, Phone No. Physician & Hospitals	Conditions and Details	Date	How Often Seen

9. Additional Remarks: _____

I declare that the above information is true and complete and shall form part of my application.

Proposed Insured's Signature

Date

Witness

Date



Diabetic Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



(to be completed by Proposed Insured)

Name _____ Birthdate _____

1. Date diabetes diagnosed: _____

2. Name and address of doctor now treating you and for how many years? _____

3. Type, amount and dosage of:
Insulin _____ Oral medication _____

4. Have you had any diabetic comas or insulin reactions? Yes No If yes, state which and frequency: _____

5. Have you had any fasting blood sugars performed in the last 6 months? Yes No
Results? _____

6. Do you follow a diabetic diet? Yes No Exercise program? Yes No

7. Do you self monitor your blood sugars with a glycometer? Yes No
Results? _____

8. How often do you test your urine? _____ Results? _____

9. Have you ever had an electrocardiogram or chest X-ray? Yes No If yes, give dates, name and address of doctor involved and results: _____

10. What is your height? _____ Weight? _____

11. Have you gained or lost weight during the past two years? Yes No If yes, give details: _____

12. Have you ever had: heart trouble chest pain high blood pressure eye trouble
albumin in the urine numbness or a tingling sensation in the limbs
Give full details including names and addresses of doctors consulted for these conditions: _____

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature

Date

Witness

Date



Check-up Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

page 1 of 1

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name _____ File # _____

1. Reason for check-up: _____

2. Results _____

3. Symptoms or problems prompting visit? Yes No

Date of onset of symptom(s)/problems: _____

Severity: _____

Diagnosis Given: _____

Treatment/Medications Given: _____

Complications and/or side effects: _____

Name, address, and phone number of attending physician: _____

4. Is any future testing, surgery, or treatment required or recommended? Yes No

If yes, provide details _____

5. If referred to another physician or medical facility, provide name, address, and date of attendance: _____

6. Please include any addition information which you feel is important: _____

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature

Date

Witness

Date



Aviation Questionnaire

Issued by American National Life Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



NAME OF APPLICANT _____ DATE OF BIRTH _____ FILE # _____

1. (A) Type of Certificate or license now held? _____ Student — If "Student," when did the Proposed Insured first obtain a Student Pilot's Certificate? _____
 _____ Private _____ Commercial _____ ATR Other (specify) _____
- (B) Does the Proposed Insured have an Instrument Flight rating? _____ Yes _____ No
- (C) Total Number of hours flown as a pilot? _____
- (D) What percentage of the Proposed Insured's flying time is
 - (i) with a qualified copilot? _____
 - (ii) in a single engine plane? _____
 - (iii) in a multi-engine plane? _____
2. If not a pilot, specify the capacity in which the Proposed Insured flies, e.g., flight surgeon, photographer, crew member, etc. _____
3. (A) When did the Proposed Insured last fly as a pilot or crew member? _____
- (B) Type of aircraft? (specify alphabetic and numeric code, propeller or jet, and give brief description.)

4. Has the Proposed Insured flown or does he/she intend to fly outside the United States? _____ Yes _____ No
 If "Yes", explain. _____
5. Has the Proposed Insured ever had an aircraft accident or been grounded, fined, or reprimanded for violation of Air Regulations? _____ Yes _____ No
 If "yes," give details. _____

Complete the following chart as it may apply

Type of Flying	Hours Contemplated Next 12 Months	Hours Past 12 Months	Hours One to Two Years Ago	Type of Flying	Hours Contemplated Next 12 Months	Hours Past 12 Months	Hours One to Two Years Ago
Commercial (Flying for pay) Scheduled Passenger Airline				Non-Commercial (Not Flying For pay) Pleasure			
Employer owned aircraft for employee transportation				Personal Business Transportation			
Other Freight Carrying or Passenger Service				Instruction As Student			
Student Instructor				Other (Ultralight, Glider, Etc)			
Crop Dusting/Aerial Spraying							
Military							

If we find your flying activities involve an extra hazard that requires an exclusion or an extra premium charge, please indicate your choice.

_____ Policy to include aviation coverage at appropriate extra premium. Despite payment of an additional premium for aviation coverage on the base policy, the aviation exclusion included in any Accidental Death Benefit Rider which may be issued with, or become part of, the policy will still be in effect.

_____ Policy to incorporate aviation exclusion rider.

I declare the above information is true and complete and shall form part of the application.

Date _____ Witness _____ Proposed Insured's Signature _____



Skin and Scuba Diving Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

page 1 of 1

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



NAME _____ FILE # _____

1. What type of equipment do you use? _____
2. (A) What are the locations of your diving activities? (cave, under ice, inland waters, ocean, ship wrecks, etc.) _____

- | | | |
|---|-------|-------|
| | YES | NO |
| (B) If you are a cave diver, are you certified by NACD or NSSDS? | _____ | _____ |
| (C) Do you ever participate in any night diving? | _____ | _____ |
| 3. Are you currently certified by one of the national training and certification organizations? | _____ | _____ |
| Name of the organization(s)? _____ | | |
| 4. Are you a member of an organized club? | _____ | _____ |
| 5. Do you ever dive alone? | _____ | _____ |
| 6. Do you dive or do you contemplate diving for compensation? | _____ | _____ |
| 7. Do you ever dive for depth records? | _____ | _____ |
| 8. Do you ever dive using experimental equipment? | _____ | _____ |

IF "YES" FOR ANY OF THE ABOVE, PLEASE GIVE DETAILS BELOW UNDER "REMARKS".

9. Particulars of diving:

Depth of Dive	Past 12 Months No. of Dives	Avg. Time Under Water per Dive	Expected Next 12 Months No. of Dives
To 50 ft. or less	_____	_____	_____
To 75 ft.	_____	_____	_____
To 100 ft.	_____	_____	_____
To 150 ft.	_____	_____	_____
To 200 ft.	_____	_____	_____
Over 200 ft.	_____	_____	_____
Date of Last Dive _____			

10. REMARKS: _____

I declare that the above information is true and complete and shall form part of my application.

Proposed Insured's Signature _____

Date _____

Witness _____

Date _____



Motor Sports Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



NAME _____ DRIVER'S LICENSE # _____ STATE ISSUED _____

FILE _____

1. Amateur _____ Professional _____

2. Do you engage in exhibitions or organized competitive motor sports? _____ YES _____ NO

3. Check below each type(s) of event(s) you pursue. Please give details in REMARKS section below:

- | | |
|--|--|
| <input type="checkbox"/> ALL TERRAIN (ATV) | <input type="checkbox"/> JET CAR EXHIBITIONS |
| <input type="checkbox"/> AUTO - CRASH | <input type="checkbox"/> KART RACERS |
| <input type="checkbox"/> AUTO - ICE | <input type="checkbox"/> MIDGET CARS |
| <input type="checkbox"/> CHAMPIONSHIP CARS | <input type="checkbox"/> MINI CARS |
| <input type="checkbox"/> DEMOLITION OR DESTRUCTION DERBY | <input type="checkbox"/> MOTOR CYCLES |
| <input type="checkbox"/> DRAG RACING | <input type="checkbox"/> OFF ROAD, DESERT, TRAIL COMPETITION |
| <input type="checkbox"/> DUNE/SAND BUGGY OR CYCLE | <input type="checkbox"/> RALLY |
| <input type="checkbox"/> ECONOMY RUNS | <input type="checkbox"/> SCOOTERS |
| <input type="checkbox"/> FIGURE 8 DEMOLITION DERBY | <input type="checkbox"/> SNOWMOBILES |
| <input type="checkbox"/> FOOTBALL / AUTO FOOTBALL | <input type="checkbox"/> SPORTS CARS |
| <input type="checkbox"/> DEMOLITION DERBY OR SOCCER | <input type="checkbox"/> SPRINT CARS |
| <input type="checkbox"/> FORMULA RACING | <input type="checkbox"/> STOCK CARS |
| <input type="checkbox"/> GYRO - STABILIZED LAND OR | <input type="checkbox"/> TIME SPEED TRIALS |
| <input type="checkbox"/> WATER VEHICLES | <input type="checkbox"/> WHEELIE COMPETITIONS |
| <input type="checkbox"/> HILL CLIMB | <input type="checkbox"/> OTHERS (explain in REMARKS below) |
| <input type="checkbox"/> HOVERCRAFT AND HYDROFOILS; | |
| <input type="checkbox"/> AMPHIBIANS | |

TYPES OF RACES*	MAXIMUM SPEED	LAST 12 MOS.		1-2 YRS AGO		PRIOR TO 2 YRS AGO		CONTEMPLATED NEXT 12 MOS.	
		RACES	MILES	RACES	MILES	RACES	MILES	RACES	MILES

(*Midget, Sport Car, Stock-Car, Championship, Drag, Motorcycle, etc.)

4. What specific type of event do you compete in with the above vehicle(s)? (road race, endurance, sprint, motorcross, etc.)

5. Please furnish the following information:

- A. What type of vehicle do you operate? _____ B. What make & model? _____
 C. Is it modified? _____ D. What is the HP? _____ E. Engine size? _____
 F. Engine displacement? _____ G. Class? _____ H. Type of fuel? (gas, nitro, etc.) _____

6. Under what sanctioning body do you normally compete? (AMA, NHRA, SCCA, USAC, etc.) _____

7. Do you anticipate any changes in your participation in the coming twelve months? If so, give details. (Different events, new class, etc.)

8. Have you had any moving traffic violations in the past three years? _____ Yes _____ No If "Yes", please furnish details:

9. REMARKS: _____

I declare that the above information is true and complete and shall form part of my application.

Date _____ Witness _____ Proposed Insured's Signature _____



Sport, Amusement, or Avocation Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



(Do not use for aviation, motor sports, racing or scuba)

INSTRUCTIONS

1. Answer each question with as much detail as possible. Additional information may be put on back.
2. If more than one sport or avocation is participated in, use separate questionnaire.
3. For Aviation use 8313; for Skin or Scuba use 8313-A; for Motor Sports use 8313-B; for Racing use 8313-D

EXAMPLES WHEN FORM REQUIRED

- Ballooning
- Bungee Jumping
- Hang Gliding
- Horse Racing
- Mountaineering
- Parachuting
- Powerboat Racing
- Rock Climbing
- Snowmobiling
- Spelunking

What is the activity in which you participate? _____

What National clubs or associations are you affiliated with in connection with this activity? _____

List any special licenses, professional or amateur titles you hold in connection with this activity _____

Do you participate for monetary gain or profit? Yes No If yes, give details _____

Earnings: This year _____ Last Year _____ 2 years ago _____ 3 years ago _____

In what geographical locations do you normally participate in this sport or avocation? (i.e., specific track or body of water, composition and shape of track, state or foreign country, etc.) _____

Do you or have you ever participated in any experimental forms of this sport or avocation? Yes No

If Yes, give full details _____

How long have you been participating in this sport or avocation? _____

How frequently do you expect to participate in the past 12 months? _____

How frequently do you expect to participate in the next 12 months? _____

What is the greatest height/depth/speed you have obtained? _____

How many times have you attained this height/depth/speed? _____

What is the average height/depth/speed? _____

What is the average length of time you spend in each instance of participation in this activity? _____

Date _____

Witness _____

Signature of Applicant _____



Racing Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name of Proposed Insured _____ Date of Birth _____

(1) Have you engaged in or do you contemplate engaging in any of the following form(s) of racing?

- Automobile Yes No
- Motorcycle Yes No
- Motorboat Yes No
- Hydroplane Yes No
- Other(s) Yes No

Specify _____

If "Yes", give details below

Types of Racing*	1-2 Years Ago		Last 12 Months		Average Speed of Fastest Race	Fastest Speed Attained	Contemplated Next 12 Month	
	Number of Races	Total Miles Raced	Number of Races	Total Miles Raced			Number of Races	Total Miles

*Examples

- Automobile — midget, sports car, stock car, championship, drag, kart
- Motorcycle — hill climbing, cross country, circular track
- Motorboat — unmodified, modified, experimental
- Unlimited hydroplane — jet, other

(2) Do you own a competitive vehicle(s)? _____ If yes, give type(s) _____

(3) Over what period of the year do you race? (e.g., month, six months, entire year) _____

(4) How far do you travel to race? _____

(5) Have you ever competed or do you contemplate competing outside the United States? _____
If yes, give details _____

(6) Over what type of track do you race? (e.g., oval, simulated road) _____

(7) Do you race professionally or for cash prizes? _____

(8) Additional remarks clarifying answers to above questions: _____

I hereby represent that all the above statements and answers to all the above questions are complete and true, and I agree that they shall form a part of my application and become a part of any contract of insurance issued in consequence of such application.

Dated _____ this _____ day of _____,

Witness

Signature of Proposed Insured



Foreign Travel Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

page 1 of 1

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name _____ Birthdate _____

1. Where will you be travelling? _____

2. Describe purpose of travel and duties you will have while travelling. _____

3. Will you be travelling within the country? Yes No

4. Name the city in which you will live, or the nearest metropolitan area, and the distance to that metropolis.

City _____ Distance _____

5. Date of arrival _____

6. Anticipated date of permanent return to country of permanent residence _____

7. Birthplace _____ Citizenship _____

8. If not a U.S. or Canadian citizen, indicate type of visa _____

9. Country of permanent residence _____ How long? _____

10. Occupation (Describe duties.) _____

11. Are you on any medication that you will continue taking on this trip? Yes No

If "Yes," for what disorder? _____

I declare that the above information is true and complete and shall form part of the application.

Proposed Insured's Signature

Date

Witness

Date



Proposed Insured's Chest Pain Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



To be completed by the Proposed Insured

Name of Proposed Insured: _____ Date of Birth: _____

- A. Have you ever had:
- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Palpitation? Skipping of heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |

Please give details of all "Yes" answers - Dates, Durations, Results, Doctors' names and addresses.

- B. If pain was experienced in chest did it involve:
- | | | |
|---|--------------------------|--------------------------|
| 1. Middle of chest? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Left side of chest? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Left Shoulder, arm or hand? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Both shoulders or arms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Sense of pressure of constriction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sweating | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Was it associated with: | | |
| Exertion? Exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Excitement? Strain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Emergency medical care? | <input type="checkbox"/> | <input type="checkbox"/> |

- C. If "Yes" answers please report:
1. Approximate date of first attack? _____
 2. Date of last attack? _____
 3. How frequent: per day, week or month? _____
 4. Duration of average attack? _____
 5. Were you hospitalized? How long? _____
 6. Were you confined at home? How long? _____
 7. How long convalescent? _____
 8. Date of return to work? Restrictions? _____
 9. How many hours do you work daily? _____
 10. What medicine are you now taking? _____

D. Please give names and addresses of all your attending doctors. _____

E. What diagnosis was made concerning your heart condition? _____

Signature: _____ Date: _____

Proposed Insured

Please use the back of this sheet, if necessary, to report details which will clarify this medical history.



Blood Pressure Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

page 1 of 1

Mailing Address: PO Box 1720, Galveston, TX 77553-1720

Business (800) 672-9960

Fax (409) 766-6589



Name: _____ Birthdate: _____ File #: _____

1. What was your highest blood pressure reading? _____ Please provide the date of this reading: _____

2. What was your lowest blood pressure reading? _____ Please provide the date of this reading: _____

3. Have you received treatment for blood pressure? _____ If "yes:"

A. Name, address and phone number of doctor(s): _____

B. When did treatment begin? _____

C. Last blood pressure reading and date of visit: _____

D. Medication(s) prescribed and dosage: _____

4. Have you experienced or been treated for any of the following?

- Stroke Severe headaches High cholesterol Chest pains Circulation problems Other

Please provide details. _____

5. Please provide results of any special studies: (X-Rays, EKG, Lab Tests, etc.) _____

6. Do you have any other significant health history? _____ If "yes," please provide details: _____

I declare that the above information is true and complete and shall form part of my application.

Date: _____ Witness: _____

Proposed Insured's Signature: _____



Application - Additional Beneficiary Page for Life Insurance

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999



Provide corresponding application / policy number: _____ / Select the appropriate box for which this page applies.

Primary Proposed Insured Additional Proposed Insured Other Insured Rider _____

1. PRIMARY PROPOSED INSURED

a. Last name _____ First name _____ M.I. _____ Social Security/Tax ID number _____

b. Date of birth: Month/Day/Year _____ c. Residence address: Number/Street _____ d. City _____ e. State _____ f. ZIP _____

2. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name _____ First name _____ M.I. _____ Social Security/Tax ID number _____

b. Date of birth: Month/Day/Year _____ c. Residence address: Number/Street _____ d. City _____ e. State _____ f. ZIP _____

3. ADDITIONAL BENEFICIARY INFORMATION *(Unless specified, all beneficiaries in the same class share equally.)*

Primary: Last name	First name	M.I.	Relationship to proposed insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
Contingent: Last name	First name	M.I.	Relationship to proposed insured	Date of Birth: Mo./Day/Yr.	Gender	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

4. USE FOR ADDITIONAL BENEFICIARY DESIGNATIONS OR FOR SPECIAL BENEFICIARY SETTLEMENT OPTIONS:

Date: Month/Day/Year _____ Signature of primary proposed insured (Or guardian, if proposed insured is under age 16)

_____ X _____

Witnessed by: Signature of licensed agent _____ Signature of additional person(s) proposed for insurance

X _____ X _____

Print agent's name _____ Signature of additional person(s) proposed for insurance

_____ X _____

Agent's state license number / company personal code _____ Signature of owner if other than proposed insured

_____ X _____

SERFF Tracking Number: AMNA-125968137 State: Arkansas
Filing Company: American National Insurance Company State Tracking Number: 41678
Company Tracking Number: FORM 10193
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Form 10193
Project Name/Number: /

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Certification/Notice
Comments:
Attachment:
AR - CERTIFICATION OF COMPLIANCE.pdf

Item Status: **Status**
Date:

Bypassed - Item: Application
Bypass Reason: N/A - this filing is for an application and its questionnaires
Comments:

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability
Comments:
Attachment:
AR - SOV - STATEMENT OF VARIABILITY.pdf

Item Status: **Status**
Date:

Satisfied - Item: Cover Letter
Comments:
Attachment:
AR- Cover Letter.pdf



American National Insurance Company

ARKANSAS

CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19
Rule & Regulation 49 ACA 23-79-138 and
Bulletin 11-88 ACA 23-80-206 (Flesch Certification, minimum of 40) – Form 10193-AR and supplemental documents listed below achieves a score of at least 50.0

Form 10193-AR - Application for Life Insurance
3517- AR - Declaration of Insurability – application supplement
10228 - Additional Beneficiary – application supplement
4643 - Drug Use Questionnaire – underwriting questionnaire
4644 - Alcohol Use Questionnaire – underwriting questionnaire
4687 - Respiratory Questionnaire – underwriting questionnaire
4688 - Epilepsy/Seizure Questionnaire – underwriting questionnaire
4689 - Disabled Applicant Questionnaire – underwriting questionnaire
4690 - Diabetic Questionnaire – underwriting questionnaire
4691 - Check-Up Questionnaire – underwriting questionnaire
8313 - Aviation Questionnaire – underwriting questionnaire
8313-A - Skin and Scuba Diving Questionnaire – underwriting questionnaire
8313-B - Motor Sports Questionnaire – underwriting questionnaire
8313-C - Sports, Amusement or Avocation Questionnaire – underwriting questionnaire
8313-D - Racing Questionnaire – underwriting questionnaire
9264 - Foreign Travel Questionnaire – underwriting questionnaire
10065 - Chest Pain Questionnaire – underwriting questionnaire
10100 - Blood Pressure Questionnaire – underwriting questionnaire

Rex D. Hemme Vice President &
Actuary American National Insurance
Company

tracey.johnfroe@anico.com Phone:
(409) 763-4661 x5438 Fax: (409) 766-6933



AMERICAN NATIONAL INSURANCE COMPANY

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EXPLANATION OF VARIABLE FIELDS WITHIN FORM 10193-AR

The Application for Life Insurance form submitted contains the variable fields as described below:

Mailing Address: This field will only be updated in the event the mailing address where applications are sent is changed.

Business Phone and Fax Number: This field will only be updated in the event the business and fax phone numbers are changed.

EXPLANATION OF VARIABLE FIELDS WITHIN APPLICATION SUPPLEMENTAL AND QUESTIONNAIRE FORMS

- 3517-AR – Declaration of Insurability – application supplement
- 10228 – Additional Beneficiary – application supplement
- 4643 – Drug Use Questionnaire – underwriting questionnaire
- 4644 – Alcohol Use Questionnaire – underwriting questionnaire
- 4687 – Respiratory Questionnaire – underwriting questionnaire
- 4688 – Epilepsy/Seizure Questionnaire – underwriting questionnaire
- 4689 – Disabled Applicant Questionnaire – underwriting questionnaire
- 4690 – Diabetic Questionnaire – underwriting questionnaire
- 4691 – Check-Up Questionnaire – underwriting questionnaire
- 8313 – Aviation Questionnaire – underwriting questionnaire
- 8313-A – Skin and Scuba Diving Questionnaire – underwriting questionnaire
- 8313-B – Motor Sports Questionnaire – underwriting questionnaire
- 8313-C – Sports, Amusement or Avocation Questionnaire – underwriting questionnaire
- 8313-D – Racing Questionnaire – underwriting questionnaire
- 9264 – Foreign Travel Questionnaire – underwriting questionnaire
- 10065 – Chest Pain Questionnaire – underwriting questionnaire
- 10100 – Blood Pressure Questionnaire – underwriting questionnaire

All forms listed above contain the variable fields:

Mailing Address: This field will only be updated in the event the mailing address where applications are sent is changed.

Business Phone and Fax Number: This field will only be updated in the event the business and fax phone numbers are changed.



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February 27, 2009

Arkansas Insurance Department
Compliance - Life and Health
1200 West Third Street
Little Rock AR 72201-1904

American National Insurance Company (NAIC: 60739 FEIN: 74-0484030)

Filing of:

Form 10193-AR

Form 10100

Form 10065

Form 9264

Form 8313

Form 8313-A

Form 8313-B

Form 8313-C

Form 8313-D

Form 4643

Form 4644

Form 4687

Form 4688

Form 4689

Form 4690

Form 3517-AR

Form 10228

SERFF Tracking Number AMNA-125968137

Company Tracking Number: 10193

Dear Sir or Madam,

Please find the above referenced forms attached for your department's review and approval. These are new forms and are not intended to replace any previously approved forms.

Form 10193-AR is an Application for Life Insurance. It will be used on all lines of fully underwritten life insurance products offered by American National Insurance Company including, but not limited to:

- Participating Whole Life (Participating and Non-Participating);
- Traditional Universal Life;
- Indexed Universal Life;
- Variable Universal Life; and
- Term Life

This application will be attached to and made a part of the policy contract.

Within the application, there are medical history and other similar type questions used to assist Us in determining the insurability and risk class of the applicant. For some of these questions, a 'yes' answer will prompt the use of a supplemental questionnaire in order to gather more information. In addition to a 'yes' answer, the underwriter can request the completion of a supplement questionnaire at their discretion, usually based on findings in a report or medical examination on the



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applicant obtained during the underwriting process. When used, these questionnaires will be attached to and considered a part of the application, which is attached to and made a part of the policy.

These questionnaires are as follows:

- Form 10100 – Blood Pressure Questionnaire
- Form 10065 – Proposed Insured's Chest Pain Questionnaire
- Form 9264 – Foreign Travel Questionnaire
- Form 8313 – Aviation Questionnaire
- Form 8313-A – Skin and Scuba Diving Questionnaire
- Form 8313-B – Motor Sports Questionnaire
- Form 8313-C – Sport, Amusement or Avocation Questionnaire
- Form 8313-D – Racing Questionnaire
- Form 4691 – Check-Up Questionnaire
- Form 4690 – Diabetic Questionnaire
- Form 4689 – Disabled Applicant Questionnaire
- Form 4688 – Epilepsy/Seizure Questionnaire
- Form 4687 – Respiratory Questionnaire
- Form 4644 – Alcohol Use Questionnaire
- Form 4643 – Drug Use Questionnaire

Form 3517-AR is the Declaration of Insurability form. This form is used in conjunction with the application when a Premium Payor Benefit/Rider is applied for. The person named as the Premium Payor must complete the form and submit the completed form to Us with the application for life insurance. When used, this form will be attached to and considered an extension of the application, and will become a part of the policy.

Form 10228 is the Application - Additional Beneficiary Page for Life Insurance form. This form is used to designate beneficiaries for the policy being applied for. At times, multiple beneficiaries can be named, or space is an issue on the application when a long name or title needs to be written. Also, the applicant may have special instructions regarding the designation of a beneficiary(ies). In lieu of being restricted by the space provided on the application, this form may be completed and submitted with the application. When used, this form will be attached to and considered an extension of the application, and will become a part of the policy.

Additional components / information associated with this filing are as follows and have been enclosed (when applicable) for your review:

- Statement of Variability
- Certification/Notice
- Payment for the required filing fee has been transmitted via EFT through SERFF in the amount of \$100

Should any additional information be required, or if there are any questions, please contact me at the phone number or e-mail address provided above.